Mrs S J Pillow

Green Bank

Inspection report

11 Hastings Road
Bexhill-on-sea
TN40 2FQ

Tel: 01424211704
Website: www.greenbankcarehome.com

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Green Bank provides accommodation, care and support for up to 20 people who live with dementia, mental health conditions and long- term health needs such as diabetes. At the time of our inspection there were 17 people living at the home.

We inspected using our targeted methodology developed during the Covid19 pandemic to examine specific risks and to ensure people were safe.

People's experience of using this service and what we found:
The provider's systems failed to identified that care and treatment was not provided in a safe way. Audits did not always identify risks to people, safeguarding concerns and a failure to report incidents. Staff practice was not effectively monitored.

People were not protected from potential harm and abuse. Some people had been subject to abuse and this had not always been escalated and investigated to prevent further occurrences. Abuse or improper treatment was not always reported, investigated or acted on. Care and treatment was not consistent. People 's specific health and safety needs were not always identified and planned for. People's safety therefore was at risk and this had not been addressed by the registered manager or provider. For example, people were not wearing slippers or shoes and therefore at risk from slips and trips.
Infection prevention control was inspected.
It was found the provider was not meeting government guidelines in regard to Covid-19. People had not been self -isolating safely in the home. There was a lack of cleaning of high traffic areas and no cleaning schedule to guide staff. Staff had not all received essential training and specific training to meet people's individual needs and there was a lack of regular supervision and competency assessments.

Staff were open and transparent when talking to inspectors during the inspection. Staff were kind to people and wanted to deliver good care.

Rating at last inspection:
The last rating for this service was Requires Improvement (published 05 February 2020) and there were three breaches of regulation. We imposed a condition on the registration of the service. The service has deteriorated to Inadequate.

Why we inspected:
We undertook this targeted inspection to check on specific concerns we had about peoples' safety and well-being and the management of risk in the service. We inspected and found there were concerns with staff training, safeguarding and accident/incident management so we widened the scope of the inspection to become a focused inspection which included all the key questions of safe and well-led.

We looked at infection prevention and control measures under the Safe key question. We look at this in all

care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

Enforcement:
We are mindful of the impact of the Covid19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the Covid19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We have identified breaches in relation to safeguarding, safe care and treatment and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.
If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Green Bank

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This was a targeted inspection due to concerns we had about people's safety, staffing levels, delivery of safe care and the governance framework to support people and staff safely.
As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing and managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team consisted of two inspectors.

Service and service type
Green Bank Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Before the inspection we reviewed the information, we held about the service and the service provider. We sought feedback from the local authority and healthcare professionals that are involved with the service. We looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law. We used all of this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection, however one had been completed in March 2020. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

Due to the COVID-19 pandemic we needed to limit the time we spent at the home. This was to reduce the risk of transmitting any infection. Therefore, we had calls with the nominated individual for the organisation. We discussed how we would safely manage an inspection without announcing the date. We also wanted to clarify the providers infection control procedures to make sure we worked in line with their guidance.

To minimise the time in the service, we asked the provider to send some records for us to review prior to and following the inspection. This included records relating to the management of the service, audits, training and supervision records and staffing rotas. However, at the time of writing this report, we had not received the majority of records requested.

During the inspection
We spoke with six people who used the service. We spoke with six members of staff including the registered manager and provider. We spent a short time in the home over two separate days and a third day talking to health professionals. This allowed us to safely look at areas of the home and to meet people, the providers and staff whilst observing social distancing guidelines. It also gave us an opportunity to observe staff interactions with people. We reviewed a range of records. This included a sample of people's care records, medicine records, and fire risk assessment.

After the inspection
We continued to seek clarification from the provider to validate evidence found, however we did not receive any of the documents requested. We received feedback following the inspection from two staff members and two health professionals.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

● Risks to people were not always identified, assessed and mitigated. Risk assessments had not been completed for people who may become anxious or distressed. There was no information in the care plan to guide staff on how to support people at this time, and staff had not received appropriate training. A person who had recently come to stay at Green Bank lived with dementia and walked with purpose was isolating and had been placed on the first floor. There was minimal staff presence to assist the person to settle and on three occasions during the inspection visit the person was found by inspectors distressed, wet and in other people's room. We informed staff and the registered manager but no action was taken. We found the person in similar circumstances during the second visit.
● People with behaviours that may challenge had a basic care plan and risk assessment to guide staff in managing their behaviours. However, these were not supported with behavioural plans and therefore there was minimal information about when an incident occurred, what action staff had taken to de-escalate the situation and whether it was effective. There was no guidance as to how to distract the person and reduce risk to them and other people and staff. Staff working were not able to tell us how they managed peoples behaviour.
● A district nurse was visiting a person who was refusing their insulin. Due to behaviours that challenged the district nurse left with out being able to administer the medicine safely. A second district nurse visited later following the person receiving a sedative. None of these challenges were in the person's care plan or risk assessment.
● Risks of low mood of people, whilst known to staff, had not always been reported to the manager or documented within the daily notes or care plans. This meant there were no management strategies in place to manage this during the pandemic. On talking with a person, they said, "I feel down and my life is nothing, I spend most of my time just sitting, my TV doesn't work. I have not seen a Dr or a nurse." There was no evidence that this person had been seen by a health professional. Discussion with the registered manager

and staff identified that they had not identified this person's changes in mood, despite it being identified in January 2020. There was no documentation that guided staff in monitoring mood changes and implementing a mananagement plan.

● People's personal safety was not always monitored, for example, people were not wearing appropriate foot wear to prevent trips and falls. People were frail and unsteady and were walking with purpose and going up and down stairs without footwear or while wearing inappropriate footwear. This increased the risk of falls. This risk had not been identified, assessed and mitigated.

● Areas of the premises were not safe and an environmental risk assessment had not been undertaken to manage the risk. We found exposed sharp nails/screws on people's furniture, a water leak in the conservatory which was coming through light/heating wiring and the floor in the shower room was slippery and broken. These were identified to the registered manager for immediate attention.

Preventing and controlling infection

● We were not assured that the provider was meeting shielding and social distancing rules. Social distancing was difficult as people had complex care needs that included living with dementia and mental health illnesses. However, people had not been risk assessed for individual measures to be considered to promote individual safety.

● The registered manager knew it would be difficult to introduce zoning and cohorting if there was an outbreak due to people living with dementia, but had not developed any plan for if there was a positive test result for a person living in the service.

● We were not assured that the provider was admitting people safely to the service. People were not appropriately isolated for 14 days after admission in line with government guidelines. People were not risk assessed to consider alternative arrangements if isolation was not possible due to their complex needs.

● We were not assured that the provider was using PPE effectively and safely. Staff had not all received specific training for COVID-19 and the use of PPE. They were not always wearing PPE effectively or line with government guidelines. For example, some staff were not wearing aprons when providing personal care. There were no areas for staff to put on PPE or remove and dispose of this equipment safely. For example, there were no pedal operated bins in the service to reduce the risk of cross-contamination.

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. The service had not been COVID-19 risk assessed and an infection control audit had not been completed since the pandemic. Cleaning staff had not received additional training on COVID-19 and cleaning practice had not been changed to reflect increased risks. For example, high touch areas had not been identified for more frequent cleaning.

● We observed staff practice that did not always promote good infection control practice. For example, dirty linen was being carried through the service without being placed in suitable bags/ containers. We also saw that cleaning trolleys were soiled and dirty. This raised the risk of cross infection. The overall cleaning of the service was poor and we found dirty bathrooms and floors in bedrooms and communal areas were not clean.

● We were not assured that the provider was making sure infection outbreaks could be effectively prevented or managed. Staff had not been given additional training on infection prevention and control (IPC) and COVID-19 and did not follow best practice to prevent infection outbreaks. For example, staff were wearing jewellery including bracelets. This prevents thorough and effective hand hygiene.

● We were not assured that the provider's infection prevention and control policy was up to date. It had not been reviewed since December 2019 and did not take account of government guidelines relating to the COVID-19 pandemic.

● We were assured that the provider was admitting people safely to the service. Guidelines had been followed when admitting people. No one was admitted without first testing negative for COVID-19 and all were located on the first floor for 14 days following admission.

● We were assured that the provider was accessing testing for people using the service and staff. All staff and people were regularly tested. No one had refused a test and contingencies were in place should someone decline.
● We were assured that the provider was preventing visitors from catching and spreading infections. Temperature checks and infection questionnaire completed by all visitors on entry to service. Relatives were able to book a time slot to visit loved ones but had to remain in the garden maintaining a safe distance between themselves and their relative. Relatives wore personal protective equipment (PPE) throughout each visit.

We have also signposted the provider to resources to develop their approach.
Staffing and recruitment
● Comments from people and staff included, "The staffing levels seem okay" and "The staff work hard they seem to get it done." Feedback from staff was mixed. One staff member said, "We don't have enough staff to give good care as I would like to." Another staff member said, "We need medicine trained staff at night as at the moment no-one can have medicines if they need it. It's not right."
● Due to staff shortages we saw that there were not enough staff to support people safely. People were left unsupervised in the dining room whilst eating despite one person being at risk from choking from a swallowing problem. One person who had recently only just come to stay at Green bank was left on the first floor and was found walking with purpose into other peoples' room and not sure where they were.
● On arrival at Green Bank for the site visit, we were informed that they were 'two staff short'. During the morning the vacancies were filled by agency care staff. There was no support or supervision of agency staff due to lack of senior staff working as part of the care team.

● We were told that agency staff had an induction and only regular staff were used. However, one agency staff member said "I was shown around but not given a list of residents, just told to get on with it." They also said, "There are some residents who need two to one care but don't always get it. I was asked to get someone up today but they need two staff."
● We requested three months of staff rotas to review staff levels however we have not received them at the point of writing this report. We were informed by staff that they had six care vacancies as staff had left. One staff member said, "There is a lot of agency staff, but they don't know our residents or how we work, so everything takes longer."
● From talking to staff and observing, we were not assured that staff had the necessary training to meet peoples' needs. Staff told us that they had not had training in managing behaviours that challenge. They also said they had not received training during the pandemic apart from infection control which was on-line.
● We requested the training programme prior to and during the inspection. At the time of writing this report the training programme had not been received. Currently there were only three staff members who could administer medicines one of whom was the registered manager and the rest were all day staff. There were no staff at night that could give medicines, which meant night medicines were given at 1930 hrs instead of the prescribed time of 2200 hrs. Some people were prescribed night sedation and medicine for anxiety on an as and when needed basis but at night there was no one qualified to administer this.
● Staff competencies had not been undertaken following completion of training. This meant that the provider could not be assured that staff were competent in their roles. We observed incorrect infection control procedures and people not having the right support when they became distressed.
● Staff told us they had not received regular supervision. One staff member said, "Supervisions are supposed to be every six months. I had one a few months ago but never saw the write up."
● We viewed one recruitment folder and found some areas that needed to be improved. For example, employment history was lacking and specific risk assessments to ensure the that the person was suitable to work with vulnerable people.

The provider had not ensured the safety of people by assessing the risks to their health and safety and doing all that is practicable to mitigate any such risks. The provider had not ensured there were sufficient staff who had the right skills and competencies to support people.
The provider had not appropriately assessed the risk of preventing, and controlling the spread of infections, including those that are health care associated such as Covid19.
This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People were not always protected from harm. We were aware that there had been allegations of abuse which were currently being investigated. There was evidence that appropriate actions to safeguard people and staff were not being followed. For example, ensuring that staff involved in the safeguarding allegations were not in the home whilst the investigation was on-going. This is to protect the staff as well as people.
● Staff and people told us of incidents of behaviours that were challenging that placed staff and other people at risk. For example, altercations where staff and other people were physically harmed and furniture thrown. Not all these incidents had been raised to the local authority safeguarding team or to CQC as required. Action had not been taken to prevent further incidents.
● The registered manager had not recognised the impact of some recent changes made to peoples' lifestyle and what it meant to people and to staff. Staff told us that people now had to be changed for bed at 3:30 pm, and have supper at 5 pm and then sent to their rooms. Staff could not tell us any rationale for this change apart from "It's what the senior wants," People were also got up and showered and dressed at 5 am and in the dining area for breakfast at 7 am. One person said, "I feel as if I'm in an army barracks." A staff member said, "People are prevented by (staff member) to go back to their rooms, it's not right." Staff could not tell us the reasons that this happened. Staff said, "It's a new routine brought in, we don't agree but we are told to do it." During the hours of 9.30am and 11.30am we saw ten people were sleeping in the lounge.
● We were told that if people did not do what was asked they were shouted at in a disrespectful way and told "If you don't sit down you can't eat." Another staff member said, "We have raised our concerns with the manager, but it's not been dealt with."
● Systems and processes had not been established and operated effectively to investigate and act on allegations of potential abuse. A staff member said, "I'd report to the manager but it's tricky now. Manager is not on my side. I feel vulnerable."
● We spoke to staff about safeguarding training. Two staff told us they had not had recent training but felt confident in identifying and reporting safeguarding issues. However some of the feedback we received during the inspection from staff regarding conduct within the service were safeguarding issues and had not been raised so they could be investigated and people made safe. Staff were not clear about the different types of abuse and of the steps to take when they identified possible abuse. we shared our concerns with the local authority safeguarding team.

The risk of harm to people had not always been mitigated as incidents were not consistently reported, recorded and investigated. Systems and processes were not established and operated effectively to investigate allegations of potential abuse.

People were not always protected from the risk of harm and is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were aware of the service whistleblowing policy. Whistleblowing allows employees to raise issues of concern whilst protecting their anonymity.

Learning lessons when things go wrong

● We were told that accidents and incidents were documented and recorded. However, the records were not available during the site visit. We requested prior, during and following the inspection the overview of accidents and incidents and these have not been produced.

● We could not confirm that all serious incidents resulting in harm to people were escalated to other organisations such as the Local Authority and CQC.

● We were not assured that learning from incidents and accidents took place. Specific details and follow up actions by staff to prevent a re-occurrence were not known by staff. Action from incidents and accidents were not shared with all staff or analysed by the management team to look for any trends or patterns. One staff member said, "I've never had feedback after things go wrong."

This has been covered in the well led section of this report.

Using medicines safely

● Medicines were stored, administered and disposed of safely. People's medication records confirmed they received their medicines as prescribed. We saw that medicines remained stored securely.

● Staff who administered medicines had had the relevant training and competency checks.

● We asked people if they had any concerns regarding their medicines. One person said, "I get my pills."

● Some people had been prescribed 'as required' (PRN) medicines. People took these medicines only if they needed them, for example, if they were experiencing pain. There were protocols in place to inform staff why these medicines may be needed. People who were prescribed medicine for anxiety had a protocol to guide staff in offering verbal reassurance before giving them medicine, this had helped prevent unnecessary use of the medicine.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has deteriorated to inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection the provider had failed to ensure that there were effective systems to assess and quality assure the service. This placed people at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

● The quality monitoring systems in place had not ensured the provider had oversight of the service. This had impacted on safe support for people within the service, medicine management, training and competencies and infection control procedures. For example, systems to monitor staff practice had not identified staff were not complying with government guidance in relation to PPE which increased the risk of infection. Government guidelines for Covid19 were not being adhered to. This has been referred to in depth in the safe section of this report.
● We found records relating to safe care delivery were incomplete and not up to date so staff did not have up to date information about people. This was acknowledged by the registered manager. Staff told us, "There are no proper handovers. We have to check the system ourselves. The notes in care plans are often not written up well."
● Incidents and accidents had not all been recorded and escalated to the Local Authority or to CQC when required. For example, people's escalating aggression and anxiety. Staff said they were told to 'medicate rather than seek advice' and support in managing behaviours that challenge.
● Staff told us that supporting people with behaviours that were unpredictable and could challenge was stressful. The provider had not ensured staff had received appropriate training to support them in this role. We were told that this was to be covered in their training programme, but staff told us they had not had the training. One staff member was seen dealing with a situation in the lounge, but it was not a good interaction as the person became more agitated and left the room anxious.
● We were given evidence of potential safeguarding matters that staff had identified but had not taken forward. For example, a member of staff shouting and swearing at people and medicine errors. These matters should have been reported to ensure people were protected from harm.

● Essential maintenance to keep people safe had not been actioned. This included a broken and unsafe radiator cover in the main communal area, where people sit and a broken ground floor window fastener which meant the building was not secure. Further areas were identified to the registered manager for immediate action.
● There were delays in requested documents and information being sent to CQC, by the management team and provider, following the inspection. Despite further requests information was not received.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people: Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Staff told us that staff meetings, surveys and handovers had not been happening. One staff member said, "No team meetings apart from one with the new senior carer but that was just them talking at us." Another staff member said, "It's changed, staff have left, agency staff, new staff." This was acknowledged by the registered manager who said " Due to the pandemic we have not had meetings."
● There was a high use of agency staff and the registered manager said all agency staff had an induction. However this was not confirmed by the agency staff we spoke with. Comments included, "I've not shadowed here. Just straight into it," "I was asked to do the tea round when I arrived but was given no details if diabetics. I was eventually given a list by another carer." "There are some residents who need two to one care but don't always get it. I was told last shift that I knew nothing and that we're useless. I just step back now."
● People told us, "I talk to staff if I need to, I am fairly happy, but it is like an army barracks now," and "I'm okay."

The provider had failed to establish and operate effective governance systems to assess, monitor and mitigate the risks to people's health, safety and welfare. Some records were not in place, accurate or complete. This is a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care
● The provider stated they valued the opportunity to meet other providers and managers to share ideas and discuss concerns at meetings and forums but this had been limited during the pandemic.

Working in partnership with others
● The registered manager told us that he worked closely in partnership with local health care and community services to improve people's health and wellbeing. Feedback from two health professionals said, "I have seen some good changes since a new staff member came to work here, People's appearance is better and bedrooms brighter. (Staff member) seems to know the residents but I don't think she is here at the moment as it seems a bit frantic today."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured the safety of service users by assessing the risks to their health and safety and doing all that is practicable to mitigate any such risks. The provider had not appropriately assessed the risk of, and preventing, detecting and controlling the spread of infections, including those that are health care associated such as Covid19; Regulation 12 12(1)(2)(a)(b)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured that systems and processes were established and operated effectively to prevent abuse of service users. Systems and processes had not been established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse. Regulation 13 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

The provider had not ensured that there were effective systems to assess and quality assure the service. Regulation (17) (1) (2) (a).

The provider had failed to maintain accurate, complete and contemporaneous record in respect of each service user.

Regulation 17 (2) (c).